2300 INTRODUCTION

The Home and Community Based Waiver (HCBW) Program recognizes that many individuals at risk of being placed in hospitals or nursing facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Nevada's Waiver for Persons with Physical Disabilities originated in 1990. Waiver service provision is based on the identified needs of the waiver recipients. Every biennium the service needs and the funded slot needs of the waiver program are reviewed by Medicaid and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of integrating persons with disabilities into the community. Nevada understands persons with disabilities are able to lead satisfying and productive lives, and are able to self-direct care when provided the needed services and supports to do so.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

2301 AUTHORITY

Section 1915(c) of the Social Security Act permits states to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services that an individual requires to remain in a community setting and avoid institutionalization. Nevada Medicaid's Home and Community Based Waiver for people with physical disabilities is an optional program approved by the Centers for Medicare and Medicaid Services (CMS). This waiver is designed to provide to eligible Medicaid waiver recipients state plan services and certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes or community settings, when appropriate.

Nevada has the flexibility to design this waiver and select the mix of waiver services that best meets the goal to keep people in the community. This flexibility is predicated on administrative and legislative support, as well as federal approval.

Statutes and Regulations:

Social Security Act: 1915 (c)
Social Security Act: 1916 (e)
Social Security Act: 1902 (w)
Omnibus Budget Reconciliation Act of 1987
Balanced Budget Act of 1997
Health Insurance Portability and Accountability Act of 1996 (HIPPA)
State Medicaid Manual, Section 44442.3.B.13
State Medicaid Director Letter (SMDL) # 01-006 attachment 4-B
Title 42, Code of Federal Regulations (CFR) Part 441, subparts G
42 CFR Part 431, Subpart E
42 CFR Part 431, Subpart B
42 CFR 489, Subpart I
Nevada's Home and Community Based Waiver Agreement for People with Physical Disabilities
Nevada Revised Statutes (NRS) Chapter 706, 446, 629, 630, 630a, and 633
Nevada Administrative Code (NAC) Chapters 706

2302 DEFINITIONS

These are brief definitions, full detail is located in the section addressing the definition.

2302.1 ACTIVITIES OF DAILY LIVING (ADL'S) & INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL'S)

Activities of daily living (ADL's) are self care activities routinely performed on a daily basis such as bathing, dressing, toileting, transferring, continence, and eating.

Instrumental activities of daily living (IADL's) capture more complex life activities and include light housekeeping, laundry, meal preparation and grocery shopping.

2302.2 ASSESSMENT

A written evaluation of each waiver applicant/recipient that includes the individual's abilities to perform activities of daily living, the individual's medical and social needs, the individual's support system and all other services received currently by the individual. This assessment is used to develop the applicant's/recipient's Plan of Care.

2302.3 ASSISTED LIVING

An array of services offered which are determined necessary to allow the recipient to remain in a community setting. These services may include: personal care services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), and therapeutic social and recreational programming provided in a home-like environment in a licensed (where applicable) community care facility in conjunction with residence in the facility. If a recipient or provider accesses an assisted living option, these services must be provided under this package.

2302.4 ATTENDANT CARE (AC)

Personal care services for waiver recipients who choose to have their personal care skilled service needs met by a personal attendant. This service includes the provision of skilled or nursing care to the extent permitted by state law. This also allows an extension to the hours authorized under the Functional Assessment (Form NMO 3244) for a specific task when there is documented medical necessity by a medical professional.

2302.5 CARE PLAN OR PLAN OF CARE

The Plan of Care is written document which identifies all of the applicant's or recipient's care and service needs. The plan of care is based on an assessment of the applicant's or recipient's health and welfare needs and is developed by the Medicaid case manager in conjunction with each applicant/recipient and/or his or her authorized representative.

2302.6 CASE MANAGEMENT

A service that assists persons with physical disabilities to access needed home and community based waiver services, Medicaid state plan services, as well as needed medical, social, educational, and all other services, regardless of the funding source for the services to which access is gained.

2302.7 CHORE SERVICE

Extended homemaker service needed to maintain the recipient's living space as a clean, sanitary, and safe environment.

2302.8 DAILY RECORD

The daily documentation completed by a provider indicating the time spent, and indicating services that were provided. This record needs to be signed by the recipient for each visit. This is not a medical record, this is a claim review record.

2302.9 DISABILITY DETERMINATION

Medicaid's physician consultant and medical professional staff make up the disability determination team. The team reviews medical documentation and determines if the applicant qualifies as being physically disabled.

2302.10 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization.

2302.11 HOMEMAKER SERVICE

Services consisting of general household activities including cleaning, laundry, shopping, and meal preparation.

2302.12 INDEPENDENT LIVING SERVICES

Instruction to develop independence in such areas as personal care, financial and household management, driving skills, mobility training, including services intended to enable the individual to function with greater independence or to prevent increased disabilities.

2302.13 INDIVIDUAL PROVIDERS

Refers to an individual that contracts with the DHCFP to provide Attendant Care (AC), Homemaker, Chore, Respite or Transportation services to Nevada Medicaid recipients. The individual provider holds a Medicaid provider number and receives all payments from Medicaid. The individual provider must meet the conditions of participation as stated in Medicaid Service Manual, Chapter 100 and Chapter 2300, and in a specific provider agreement for waiver services.

2302.14 INTERMEDIARY SERVICE ORGANIZATION (ISO)

An entity that is a contracted provider with Medicaid. The ISO acts as fiscal and supportive intermediary between Medicaid's PCA or Waiver Attendant Care program and eligible recipients for the purpose of:

a. Recruiting, employing, and training a pool of qualified and eligible Personal Care Aides (PCA), and Waiver Attendants.
b. Monitoring each PCA's and Waiver Attendant's service and quality of care provided to recipients, and
c. Directly ensuring compliance with Medicaid's legal and regulatory requirements related to the employment of PCAs and Waiver Attendants.

2302.15 NOTICE OF DECISION (NOD)

A Division of Health Care Financing and Policy document which provided federal due process notice to a recipient of a denial, termination suspension or reduction of Medicaid covered services or Waiver program.

2302.16 NURSING FACILITY LEVEL OF CARE

Identifies if an individual's total needs are such that they are routinely met on an inpatient basis in a nursing facility.

2302.17 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

An electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency.

2302.18 RESPITE SERVICE

Services provided to consumers unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

2302.19 SERVICE PLAN

A service plan is the written description of personal care service needs developed by Nevada Medicaid staff or Medicaid's designee and the recipient or the recipient's personal representative. It outlines those specific tasks which the PCA is authorized to provide for the recipient.

2302.20 SLOT

The number of available openings which may be offered to eligible recipients during each fiscal year. The number of slots available are determined by the level of legislative funding approved per fiscal year and through an agreement with CMS to fund this number of slots. Open slots refer to the number of people on the waiver in any one day. Unduplicated slots is the total number of persons that have been on the waiver in a specific time period.

2302.21 WAITING LIST

The list of waiver applicants who have been pre-screened and deemed eligible for the waiver and are waiting for a funded waiver slot.

2302.22 WAIVER YEAR

For the physically disabled waiver, the waiver year begins on January 1 and ends on December 31.

2303 POLICY

2303.1 ELIGIBILITY CRITERIA

Nevada Medicaid's Waiver for people with physical disabilities waives certain statutory requirements and offers home and community-based services to eligible recipients to assist them to remain in the community.

2303.1A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care provided in a hospital or nursing facility. Recipients on this waiver must meet and maintain Medicaid's eligibility requirements for the waiver.

2. The waiver for people with physical disabilities is limited, by legislative authority to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are full, Nevada Medicaid utilizes a waiting list for applicants who have been pre-determined to be eligible for the waiver.

3. Waiting List Prioritization

   a. First priority is nursing facility residents.

   b. Second priority is institutional only eligible Rehabilitation Case Management Services (RECAMS) recipients who request community placement.

   c. Third priority is applicants already on the waiting list for the waiver for people with physical disabilities.

4. Medicaid must assure CMS that Medicaid's total expenditure for home and community-based and other state plan Medicaid services for all recipients under this waiver will not, in any calendar/waiver year, exceed 100 percent of the amount that would be incurred by Medicaid for all these recipients if they had been in an institutional setting in the absence of the waiver. Medicaid must also document that there are safeguards in place to protect the health and welfare of recipients.

5. Waiver services may not be provided while a recipient is an inpatient of an institution.

6. Physically Disabled Waiver Eligibility Criteria

   Applicants or recipients must meet and maintain all criteria to be eligible and to remain on the Physically Disabled Waiver.

a. Eligibility for Medicaid's physically disabled waiver is determined by the combined efforts of the Division of Health Care Financing and Policy (DHCFP) (Nevada Medicaid) and the Nevada State Welfare Division (NSWD). Three separate determinations must be made for eligibility for the Physically Disabled Waiver:

1. Eligibility for the physically disabled waiver is determined by Medicaid's district office staff and authorized by Medicaid's Central Office Waiver Unit.

a. Each recipient must meet and maintain a level of care category for admission into a nursing facility. The recipient would require imminent placement in a nursing facility (within 30 to 60 days) if Home and Community Based Waiver services or other supports were not available. The district office staff assess a level of care according to the guidelines specified in Medicaid Services Manual Chapter 500, to determine the level of care or services required.

b. Each recipient must demonstrate a continued need for a physically disabled waiver service(s) to prevent placement in a nursing facility. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver.

c. The recipient must have an adequate support system. Necessary supports must be in place so that the physical environmental and the basic care needs of the recipient are met to provide a safe environment during the hours when home and community based services are not being provided.

2. Approval of the Disability Determination Request adjudicated by the Central Office Medicaid staff eligibility determination team is required.

Recipients must be certified as physically disabled by Medicaid's Central Office Disability Determination Team. Disabling impairments must result from anatomical or physiological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques and must be established by competent medical evidence. Persons with psychological, behavioral, or cognitive abnormalities associated with dysfunction of the brain as defined in Sections 12.01-12.04, and 112.02-112.12 of the Disability Evaluation Under Social Security are excluded from eligibility for the physically disabled waiver unless they also have a qualifying physical disability.

3. Eligibility determination for full Medicaid benefits is made by the Welfare Division.

   a. Recipients of the Physically Disabled Waiver must be Medicaid eligible for full Medicaid benefits for all months in which waiver services are provided.

   b. Services for the physically disabled waiver cannot be provided until and unless the applicant is found eligible in all three determination areas.

   c. Medicaid recipients in the Waiver for the People with Physical Disabilities may have to pay for part of the cost of the waiver services. The amount they are required to pay is called patient liability. SSI recipients do not have any patient liability.

      1. Patient liability is determined by the Eligibility Certification Specialist (ECS) in the local Welfare Division District Office. The following are excluded when determining patient liability.

         a. A maintenance allowance to care for the recipient's needs (rent, utilities, food, etc.) in the amount of 300% of the SSI need standard.

         b. A maintenance allowance for the spouse/dependent child(ren) (the ECS determine if the family members qualify for the deduction and the allowable amount of the deduction).

         c. Payments made by the recipient for health insurance premiums, deductibles and co-insurance charges not paid by Medicaid or other insurance, except for Medicare.

         d. Payments made by the recipient for medical care, recognized under State law, but not covered by the Medicaid program or other insurance. Payments for care which above the Medicaid program limits are not excluded when determining patient liability.

      2. When a case is approved or patient liability changes, the recipient, Medicaid's central office waiver unit and

Medicaid's fiscal intermediary are notified by the ECS of the patient liability amount and the effective date. Collection of patient liability is the responsibility of Medicaid's central office.

Patient liability for new approvals is effective on the first day of the month of approval.

When a recipient's income changes, patient liability is adjusted beginning with the month of the change. ECS notifies Medicaid's central office waiver unit of this change.

3. When a recipient is discharged from the waiver, patient liability is prorated according to the number of days the recipient received waiver services during the month. If patient liability is inadvertently collected before discontinuing waiver services, the remaining balance, as determined by the ECS, must be refunded to the patient.

4. The actual amount of the patient liability is either the amount determined by the ECS or the actual cost of waiver services during the month, whichever is less. This amount is deducted from the amount billed to Medicaid for waiver services whether or not it is collected from the recipient. If no waiver service are provided during a month (e.g. a new case where services aren't initiated until after Medicaid eligibility approval), there is no patient liability.

5. Failure to pay patient liability is grounds for termination of waiver services.

2303.1B PROVIDER RESPONSIBILITIES

1. Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering service.

2. Medicaid Central Office is responsible to collect patient liability.

2303.1C RECIPIENT RESPONSIBILITIES

Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the Physically Disabled Waiver.

2303.1D MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The children made eligible for Medicaid through their enrollment in the waiver for people with physical disabilities receive all the medically necessary Medicaid coverable service available under EPSDT. A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary service that are required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2303.2 WAIVER SERVICES

Nevada Medicaid determines which services will be offered under the Physically Disabled Waiver. Providers and recipients must agree to comply with the requirements for service provision.

2303.2A COVERAGE AND LIMITATIONS

Under this waiver, the following services are covered if identified in the plan of care as necessary to avoid institutionalization:

1. Case Management,
2. Homemaker Services,
3. Chore Services,
4. Respite,
5. Environmental Accessibility Adaptations,
6. Extended Transportation,
7. Specialized Medical Equipment and Supplies,
8. Personal Emergency Response System (PERS),
9. Assisted Living Services,
10. Independent Living Services,
11. Home Delivered Meals,

12. Extended Dental, and

13. Personal Assistance Service Attendant Care.

2303.2B PROVIDER RESPONSIBILITY

1. All Providers

   a. All providers for the physically disabled waiver must receive a Physically Disabled Waiver provider number (58) from Medicaid's Provider Support Unit.

   b. All providers may only provide services that have been identified in the Client Care Plan and that have prior authorization.

   c. Payments will not be made for services provided by a recipient's spouse, a child's parent, a legal guardian, or a legally responsible adult.

2. Provider Agencies (not applicable to Individual Providers)

   a. Payment for services must be authorized by the district office case manager with a Prior Authorization Request (PAR).

   b. Agencies employing providers of service to the waiver program must arrange training in at least the following subjects:

      1. policies, procedures and expectations of the contract agency relevant to the provider, including recipient's and provider's rights and responsibilities;

      2. procedures for billing and payment;

      3. record keeping and reporting;

      4. information about the specific disabilities of the persons to be served and, more generally, about the types of disabilities among the populations the provider will serve, including physical and psychological aspects and implications, types of resulting functional deficits that result, and service needs;

      5. recognizing and appropriately responding to medical and safety emergencies; and

6. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding recipient direction and the independent living philosophy; respecting consumer rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting personal property; active listening and responding; emotional support and empathy; ethics in dealing with the recipient, family and other providers; handling conflict and complaints; dealing with death and dying; and other topics as relevant.

c. Provider agencies are responsible for securing initial and annual tuberculosis testing of employees. Documentation of a negative tuberculosis test is required prior to employment and annually thereafter.

d. Provider agencies are responsible for securing criminal history clearances obtained from the Federal Bureau of Investigation through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services for recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse.

1. The Medicaid Office will not enroll any person or entity convicted of a felony or misdemeanor under Federal or State Law for any offense which the State agency determines is inconsistent with the best interest of recipients. Such determinations are solely the responsibility of the Division.

2. The Medicaid Office may deny a provider contract to any applicant, or may suspend or revoke all associated provider contracts of any provider, to participate in the Medicaid program if:

a. the applicant or contractor has been convicted of:

1. Murder, voluntary manslaughter or mayhem;

2. Assault with intent to kill or to commit sexual assault or mayhem;

3. Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;

4. Abuse or neglect of a child or contributory delinquency;

5. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS, within the past seven (7) years;

6. A violation of any provision of or NRS 200.700 through 200.760;

7. Criminal neglect of a patient as defined in NRS 200.495;

8. Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property, within the immediately preceding seven (7) years; or

9. Any other felony involving the use of a firearm or other deadly weapon within the immediately preceding seven (7) years;

10. Abuse, neglect, exploitation or isolation of older persons;

11. Kidnapping, false imprisonment or involuntary servitude;

12. Any offense involving assault or battery, domestic or otherwise;

13. Aiding, abetting or permitting the commission of any illegal act;

14. Conduct inimical to the public health, morals, welfare and safety of people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued.

15. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency, or

16. Any other offense determined by the Division to be inconsistent with the best interest of all recipients.

b. The applicant, or contractor, upon receiving information resulting from the FBI criminal background check, or from any other source,

continues to employ a person who has been convicted of an offense as listed above.

3. If an employee or independent contractor believes that the information provided as a result of the FBI criminal background check is incorrect, he or she may immediately inform the employing agency or the Division (respectively) in writing. An employing agency or the Division, that is so informed within five days, may give the employee, or independent contractor, a reasonable amount of time, but not more than sixty (60) days, to provide corrected information before terminating the employment, or contract, of the person pursuant to this section

e. Exemptions from Training

1. The agency, or its vendor agency, may exempt a prospective service provider from those parts of the required training where the agency judges the person to possess adequate knowledge or experience, or where the provider's duties will not require the particular skills.

2. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's case record. Where the recipient or other private third party functions as the employer, such individuals may exercise the exemption authority identified above.

f. Recipients Providing Training

1. Where a recipient desires to provide training and the recipient is able to state and convey his/her needs to a caregiver, the agency will allow the recipient to do so.

2. Any such decision shall be agreed to by the recipient and documented in the case record as to what training the recipient is to provide.

3. Where the recipient or other private third party functions as the employer such individual may exercise the exemption from training authority identified above.

g. Completion and Documentation of Training

The provider shall complete required training within six (6) months of beginning employment. Training as documented in the Medicaid Services Manual 2303.2 B.2.b.(4), 2303.2 B.2.b.(5), except for the service areas that require completion of CPR (as listed in the specific service area sections of this chapter) which should be

completed in a six (6) month time frame, and 2303.2 B.2.b.(6), which must be completed prior to service provision.

h. Each provider agency must have a file for each recipient. In the recipient's file, the agency must document the actual time spent providing services and the services provided. Periodically, Medicaid Central Office staff may request this documentation to compare it to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.

3. Individual Providers for Transportation, Homemaker, Chore, Respite, and Personal Assistance Service Attendant Care (not applicable to agency providers)

a. The individual provider must follow the authorized service plan in the delivery of care, not exceed the allotted time, and complete the daily record. This record must be signed by the recipient and be available for the case manager's review.

b. Homemaker service, attendant care service, and chore service require billing claim forms, CMS 1500.

2303.2C RECIPIENT RESPONSIBILITIES

The recipient or the recipient's authorized representative will:

1. notify the provider(s) and case manager of a change in Medicaid eligibility.

2. notify the provider(s) of current insurance information, including the name of other insurance coverage, such as Medicare.

3. notify the provider(s) and case manager of changes in medical status, service needs, address, and location, or of changes of status of legally responsible adult(s) or authorized representative.

4. treat all staff and providers appropriately.

5. sign the provider visit form(s) to verify services were provided.

6. notify the provider when scheduled visits cannot be kept or services are no longer required.

7. notify the provider agency of missed visits by provider agency staff.

8. notify the provider agency of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.

9. furnish the provider agency with a copy of their Advance Directives.

10. establish a back-up plan in case a waiver attendant is unable to work at the scheduled time.

11. not request a provider to work more than the hours authorized in the service plan.

12. not request a provider to work or clean for a non-recipient, family, or household members.

13. not request a provider to perform services not included in the care plan.

14. contact the case manager to request a change of provider agency or ISO.

15. sign all required forms.

2303.3 CASE MANAGEMENT

2303.3A COVERAGE AND LIMITATIONS

Case Management services include:

1. evaluation and/or re-evaluation of level of care every 12 months, as needed or as requested by the recipient;

2. assessment and/or reassessment of the need for waiver services every 12 months, as needed or as requested by the recipient;

3. development and/or review in conjunction with the recipient, of the client care plan every 12 months, as needed or as requested by the recipient;

4. communication of the client care plan to all affected providers (may be done on the PAR);

5. conduct the Functional Assessment (FA) and Service Plan on behalf of those recipients who have identified attendant care needs pursuant to MSM Chapter 3500;

6. if medically necessary, the case manager is then responsible for implementation of services and continued authorization of services pursuant to MSM Chapter 3500;

7. coordination of multiple services and/or providers;

8. Complete a prior authorization for all waiver and PCA services;

9. identifying resources to meet the recipient's needs;

10. locating and assisting to develop resources in the community to meet the identified unmet needs;

11. monitoring and documenting the quality of care through monthly contact;

12. determination of cost effectiveness of waiver services for an individual;

13. preparing and reviewing necessary billing for Medicaid payments and authorizing payment for waiver services;

14. monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient;

15. Making certain that the recipient retains freedom of choice in the provision of services;

16. Notifying all affected providers of changes in the recipient's medical status, service needs, address, and location, or of changes of the status of legally responsible adults or authorized representative;

17. Notifying all affected providers of any unusual occurrence or changed in status of a waiver recipient;

18. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;

19. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

2303.3B PROVIDER RESPONSIBILITIES

Employees of the Division of Health Care Financing and Policy (DHCFP), Medicaid Services Specialist I, II, or III are qualified as Medicaid case managers for the Physically Disabled Waiver Program. These employees have experience in functional assessments and assisting the recipient in the development of the client care plan to meet the basic needs and living goals of recipients. Professional or medical licensure recognized by a Nevada Professional State Board, such as social worker, registered nurse, occupational therapist, physical therapist is required. A licensed practical nurse may complete back up case management, operating under a previously developed level of care and plan of care under the supervision of the primary case manager.

2303.3C RECIPIENT RESPONSIBILITIES

1. Participate in the waiver assessment and reassessment process, accurately representing your skill level needs, wants, resources, and goals.

2. Together with the waiver case manager, develop and/or review the client care plan.

2303.4 HOMEMAKER SERVICES

2303.4A COVERAGE AND LIMITATIONS

1. Homemaker services are provided by individuals or agencies under contract with Nevada Medicaid.

2. Homemaker services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home.

3. Nevada Medicaid is not responsible for replacing damaged goods in the provision of service.

Homemaker services include:

a. general cleaning, including mopping floors, vacuuming, dusting, cleaning the stove, changing and making beds, washing dishes, defrosting and cleaning the refrigerator, keeping bathrooms and the kitchen clean, and washing windows as high as the homemaker can reach while standing on the floor;

b. shopping for food and needed supplies;

c. planning and preparing varied meals, considering both cultural and economic standards of the recipient, preparing tray meals when needed, and preparing special diets under medical supervision;

d. washing, ironing and mending the recipient's personal laundry. The recipient pays any laundromat and or cleaning fees;

e. assisting the recipient and family members or caregivers in learning a homemaker routine and skills, so the recipient may carry on normal living when the homemaker is not present;

f. accompanying the recipient to homemaker activities such as shopping or the laundromat which must be made using public transportation at the recipient's expense, or as a companion (not the driver) in another's private car;

g. routine clean-up after up to 2 household pets.

4. Activities the homemaker shall not perform and for which Medicaid will not pay include the following:

a. transporting (as the driver) the recipient in a private car;

b. cooking and cleaning for the recipient's guests, other household members, or for entertaining;

c. repairing electrical equipment;

d. ironing sheets;

e. giving permanents, dying or cutting hair;

f. accompanying the recipient to social events;

g. washing walls;

h. moving heavy furniture, climbing on chairs or ladders;

i. purchasing alcoholic beverages which were not prescribed by the recipient's physician;

j. doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow covered areas, and vehicle maintenance.

5. If the applicant/recipient is in a Medicaid or Medicare funded hospice program, the applicant/recipient is not eligible to receive this waiver service.

2303.4B PROVIDER RESPONSIBILITIES

1. All Providers

a. All persons performing services to recipients from this category will have criminal history clearances obtained from the Federal Bureau of Investigation through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services to recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. Reference Section 2303.2B2.d of this Chapter.

b. Persons performing homemaker tasks shall meet the standards established by State Homemaker Programs operated by the Division for Aging Services. Providers are required to arrange and receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment.

c. Spouses of recipients, a child's parent, a legally responsible adult, or a legal guardian may not be paid for homemaker services.

d. Providers will inform recipients Nevada Medicaid is not responsible for replacement of goods damaged in the provision of service.

e. Sign the daily record form, reflecting accurately the service given and the time spent providing the service.

2. Provider Agencies

No additional responsibilities.

3. Individual Providers

a. The individual provider will need to understand the assigned tasks, the allotted time, record keeping responsibilities, and billing procedures for provided waiver services.

b. Individual providers must document the time spent and services provided to the recipient on a daily record. This record must be signed by the recipient and be available for the case manager's review.

c. Homemaker service requires billing claim forms, CMS 1500, be initialed by a Medicaid case manager.

2303.5 CHORE SERVICES

2303.5A COVERAGE AND LIMITATIONS

1. This service includes heavy household chores such as:

a. cleaning windows and walls.
b. shampooing carpets.

c. tacking down loose rugs and tiles.

d. moving heavy items of furniture in order to provide safe access.

e. minor home repairs.

f. removing trash and debris from the yard.

2. Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which, otherwise left undone, poses a home safety issue. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization. This is not a skilled, professional service.

3. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supercede any waiver program covered services.

2303.5B PROVIDER RESPONSIBILITIES

1. All persons performing services to recipients from this category will have criminal history clearances obtained from the Federal Bureau of Investigation through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services to recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. Reference in Section 2303.2B2.d of this Chapter.

2. Persons performing heavy household chores and minor home repair services need to maintain the home in a clean, sanitary, and safe environment.

   All individuals performing these services must:

   a. be a U.S. citizen or legal alien.

   b. be at least 18 years of age.

   c. have a valid Social Security card.

   d. be able to read, write, and to follow written or oral instructions.

   e. be physically capable of performing heavy household and/or yard activities (e.g. snow shoveling).

f. have experience and/or training in performing heavy household activities and minor home repair (e.g., carpet cleaning, etc).

3. Individual Providers

a. The individual provider will need to understand the assigned tasks, the allotted time, record keeping responsibilities, and billing procedures for provided waiver services.

b. Individual providers must document the time spent and services provided to the recipient on a daily record. This record must be signed by the recipient and be available for the case manager's review.

c. Chore services require billing claim forms, CMS 1500, be initialed by a Medicaid case manager.

2303.6 RESPITE CARE

2303.6A COVERAGE AND LIMITATIONS

1. Respite care is provided for relief of the primary caregiver.

2. Respite care is limited to 120 hours per year per individual.

3. Respite care will be provided in the individual's home or place of residence.

4. If the applicant/recipient is in a Medicaid or Medicare funded hospice program, the applicant/recipient is not eligible to receive this waiver service.

2303.6B PROVIDER RESPONSIBILITIES

1. All persons providing respite services to recipients from this category will have criminal history clearances obtained from the Federal Bureau of Investigation through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services to recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. As referenced in Section 2303.2B2.d. of this Chapter.

2. Respite providers must:

a. perform general assistance with ADLs and IADLS and provide supervision to functionally impaired recipients in their homes to provide temporary relief for a primary caregiver;

b. have the ability to read and write and to follow written or oral instructions;

c. have had experience and or training in providing the personal care needs of people with disabilities;

d. meet the requirements of NRS 629.091 in Section 2305.2 of this Chapter, if a respite provider is providing attendant care services that are considered skilled services;

e. demonstrate the ability to perform the care tasks as prescribed.

f. be tolerant of the varied lifestyles of the people served;

g. identify emergency situations and act accordingly, including completion of CPR certification which may be obtained outside the agency;

h. have the ability to communicate effectively and document in writing services provided;

i. maintain confidentiality regarding details of case circumstances;

k. arrange training in personal hygiene needs and techniques for assisting with activities of daily living, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment, homemaking and household care.

3. Individual Providers

a. The individual provider will need to understand the assigned tasks, the allotted time, record keeping responsibilities, and billing procedures for provided waiver services.

b. Individual providers must document the time spent and services provided to the recipient on a daily record. This record must be signed by the recipient and be available for the case manager's review.

2303.7 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

2303.7A COVERAGE AND LIMITATIONS

1. Adaptations may include the purchase of environmental controls, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient. Adaptations must be prior authorized and are subject to legislative budget constraints.

2. All services, modifications, improvements or repairs must be provided in accordance with applicable state or local housing and building codes.

3. Excluded Adaptations

   a. Improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

   b. Adaptations which increase the total square footage of the home.

2303.7B PROVIDER RESPONSIBILITIES

1. All agencies contracting with Nevada Medicaid who provide environmental accessibility adaptation assessments will employ persons who have graduated from an accredited college or university in Special Education, rehabilitation, rehabilitation engineering, occupational or speech therapy or other related fields and who are licensed to practice if applicable and have at least one year experience working with individuals with disabilities and their families or graduation from high school and three years experience working with individuals with disabilities and their families as a technologist and possess a RESNA Technology Certification.

2. All sub-contractors must be licensed or certified if applicable. Modifications, improvements or repairs must be made in accordance with local and state housing and building codes.

3. Durable medical equipment providers must meet the standards to provide equipment under the Medicaid State Plan Program.

4. All providers must be in good standing with the local Better Business Bureau.

2303.8 EXTENDED TRANSPORTATION

2303.8A COVERAGE AND LIMITATIONS

1. Transportation services are offered in order to enable recipients served on the waiver to gain access to waiver and other community services, activities, and resources. This service is offered in addition to medical transportation required under 42 CFR 431.53, and transportation services under the State Plan, defined in 42 CFR 440.170(a) (if applicable), and shall not replace them.

2. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

3. Transportation services provide for the necessary travel of a recipient served by the waiver to and from places at which the recipient is receiving services recommended in the plan of care.

4. The need for transportation as part of a larger package of services designed to prevent institutionalization must be identified in the social/health assessment.

5. When possible, regularly scheduled public transportation and/or paratransit services shall be used.

6. When possible, transportation services shall be coordinated with the efforts of voluntary agencies and other agencies serving community groups.

3203.8B PROVIDER RESPONSIBILITIES

1. Personnel

   a. Any person operating a motor vehicle which transports people with disabilities, shall

      1. have an appropriate operator's license from the Department of Motor Vehicles;

      2. be covered by liability insurance;

      3. meet the requirements of the Motor Vehicle Department for operating a motor vehicle.

   b. Family members, neighbors or friends may be paid where no other transportation is available and it is deemed necessary by the care plan.

   c. All public carriers providing services to waiver recipients are regulated under NRS 706 and NAC 706.

2. Individual Providers

a. The individual provider will need to understand the assigned tasks, the allotted time, record keeping responsibilities, and billing procedures for provided waiver services.

b. Individual providers must document the time spent and services provided (including trip information) to the recipient on a daily record. This record must be signed by the recipient and be available for the case manager's review.

2303.9 SPECIALIZED MEDICAL EQUIPMENT

2303.9A COVERAGE AND LIMITATIONS

1. Specialized medical equipment and supplies are those devices, controls, or appliances specified in the plan of care that enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

2. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan.

3. Items reimbursed with waiver funds shall be, in addition to any medical equipment and supplies, furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.

4. All items shall meet applicable standards of manufacture, design, and installation.

5. Vehicle Adaptations
All modifications and equipment must be purchased from authorized dealers, meet acceptable industry standards, and have payment approved by the case manager.

6. Assistive Technology
All equipment must be purchased from authorized dealers when appropriate. Equipment must meet acceptable standards (e.g., Federal Communications Commission and/or Underwriter's Laboratory requirements when applicable, and requirements under the Nevada Lemon Law NRS).

7. Supplies
Supplies must be purchased through a provider enrolled to provide such services under the existing state Medicaid plan or as otherwise approved by Medicaid for services under this waiver.

2303.9B PROVIDER RESPONSIBILITIES

Nevada Medicaid requires any non-exempt business that intends to provide durable medical equipment to Nevada Medicaid recipients, either directly or indirectly, be licensed by the State Board of Pharmacy as a Medical Devices, Equipment and Gases (MDEG) provider or wholesaler pursuant to the provisions of Nevada Administrative Code (NAC) Chapter 639.

2303.10 PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

2303.10A COVERAGE AND LIMITATIONS

1. PERS is an electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to the recipient's phone and programmed to signal a response center once the "help" button is activated.

2. PERS services are limited to those recipients who live alone, who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified and explained in the Client Care Plan. The need for PERS will be explained in the Social/Health Assessment.

2303.10B PROVIDER RESPONSIBILITIES

1. The provider is responsible for ensuring that the response center is staffed by trained professionals at all times.

2. The provider is responsible for any replacement or repair needs that may occur.

3. Providers of this service must utilize devices that meet Federal Communication Commission standards, Underwriter's Laboratory standards or equivalent standards, and be in good standing with the local Better Business Bureau.

4. Providers must inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

2303.10C RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider when the equipment is no longer working.

2. The recipient must return the equipment to the provider when the recipient no longer needs or utilizes the equipment, when the recipient terminates from the waiver program, or when the recipient moves out of state.

3. The recipient may not throw away the PERS equipment. This is leased equipment and belongs to the PERS provider.

2303.11 ASSISTED LIVING

2303.11A COVERAGE AND LIMITATIONS

1. Assisted living services are all inclusive services furnished by the assisted living provider. Assisted living services are meant to provide all support services needed in the community and may include personal care, homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/ transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility. This service may include skilled or nursing care to the extent permitted by state law. If a recipient chooses assisted living services, he/she may not receive individual waiver services, except case management specialized medical equipment and dental services.

2. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

3. Assisted Living providers are expected to furnish a full array of services except when another federal program is required to provide the service. Other individuals or agencies may also furnish care directly, or under arrangement with the assisted living provider, but the care provided by these other entities supplements that provided by the assisted living provider and does not supplant it.

4. FFP is not available in the cost of room and board.
5. If the applicant/recipient is in a Medicaid or Medicare funded hospice program, the applicant/recipient is not eligible to receive this waiver service.

2303.11B PROVIDER RESPONSIBILITIES

1. The assisted living environment must evidence a setting that provides:

   a. living units that are separate and distinct from each other;

b. Must have a central dinning room, living room or parlor and common activity center(s) except in the case of individual apartments;

c. twenty four hour on-site response staff.

2. All persons performing services to recipients from this category will have criminal history clearances obtained from the Federal Bureau of Investigation through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services to recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. Reference Section 2303.2B2.d.

3. Providers must arrange training in personal hygiene needs and techniques for assisting with activities of daily living such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids, and equipment and in identifying emergency situations and act accordingly including CPR certification which may be obtained outside the agency.

4. Caregiver Supervisors will:

a. possess at least one year of supervisory experience and a minimum of two years experience working with adults with physical disabilities, including traumatic brain injury.

b. demonstrate competence in designing and implementing strategies for life skills training and independent living.

c. possess a bachelors degree in a human service field preferably, or education above the high school level combined with the experience noted in a. above is required.

Supporting Qualifications of the Caregiver Supervisor are:

1. experience in collecting, monitoring, and analyzing service provision; ability to identify solutions and satisfy staff/resident schedules for site operations.

2. ability to interpret professional reports.

3. knowledge of life skills training, personal assistance services, disabled advocacy groups, accessible housing, and long-term care alternatives for adults with physical disabilities and/or traumatic brain injuries.

4. dependable, possess strong organizational skills and have the ability to work independent of constant supervision.

5. Assisted Living Attendants

Assisted living attendants shall provide personal care services, community integration, independent living assistance, and supervisory care to assist the recipient in following his/her plan of care.
Assisted living attendants shall possess:

a. a high school diploma or GED.

b. some post-secondary educational experience is desired.

c. a minimum of two positive, verifiable employment experiences.

d. two years of related experience is desired.

e. job experience that demonstrates the ability to teach, work independently without constant supervision, and demonstrate regard and respect for recipients and co-workers.

f. have verbal and written communication skills.

g. the ability to handle many details at the same time.

h. the ability to follow-through with designated tasks.

i. knowledge in the philosophy and techniques for independent living for people with disabilities.

j. if the attendant is providing attendant care services that include skilled services, he or she must meet the requirements of NRS 629.091 attached in Section 2305.2 of this Chapter.

Supporting Qualifications of the Assisted living attendant are:

a. dependability, able to work with minimal supervision;

b. demonstrates problem solving ability;

c. the ability to perform the functional tasks of the job.

2303.12 INDEPENDENT LIVING SERVICES

2303.12A COVERAGE AND LIMITATIONS

1. Independent Living Services include instruction or training to the recipient to develop independent living skills in such areas as:

   a. personal care;

   b. financial and household management;

   c. household and/or driving skills;

   d. mobility training;

   e. therapeutic treatment by a recreational therapist;

   f. referral for peer counseling.

This service is intended to enable the recipient to function with greater independence, to prevent additional disabilities or an increase in the severity of an existing disability, without which the recipient would require institutionalization.

2. If the applicant/recipient is in a Medicaid or Medicare funded hospice program, the applicant/recipient is not eligible to receive this waiver service.

2303.12B PROVIDER RESPONSIBILITIES

1. The Division of Health Care Financing and Policy contracts with agencies that have Independent Living Trainers.
2. Providers must demonstrate proficiency in specific areas of service such as,

   a. peer counseling;

   b. personal care assistant management;

   c. community and recreation resources, etc.

3. This service provides assistance to promote community integration and independence.

4. All persons performing services to recipients from this category will have criminal history clearances obtained from the Federal Bureau of Investigation through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine

screenings on all applicants who will perform services to recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. Reference Section 2303.2B2.d.

5. Independent Living Skills Trainers

Trainers used for independent living must have:

a. a high school diploma or a GED;

b. Some post-secondary educational experience is desired;

c. a minimum of two positive, verifiable employment experiences;

d. two years of related experience is desired;

e. job experience that demonstrates the ability to teach, work independent of constant supervision, and demonstrate regard and respect for recipients and co-workers;

f. have verbal and written communication skills;

g. the ability to handle many details at the same time;

h. the ability to follow through with designated tasks;

i. knowledge of the philosophy and principles of independent living for people with disabilities.

Supporting Qualifications of the Independent Living Skills Trainer are:

a. dependability, able to work with minimal supervision;

b. demonstrates problem solving ability;

c. the ability to perform the functional tasks of the job;

d. ability to identify emergency situations and act accordingly including CPR certification, which may be obtained outside the agency.

2303.13 HOME DELIVERED MEALS

2303.13A COVERAGE AND LIMITATIONS

Home delivered meals are the provision of meals to persons at risk of institutional care due inadequate nutrition. Home delivered meals include the planning, purchase, preparation and transportation costs of delivering one or two meals a day to a person's home. Recipients who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician.

1. Home delivered meals must be prepared by an agency, and be delivered to the recipient in his/her own home.

2. Meals provided by or in a child foster home, adult family home, community based residential facility, or adult day care are not included, nor is meal preparation.

3. The direct purchase of commercial meals, frozen meals, Ensure, or other food or nutritional supplements is not allowed under this service category.

4. Home delivered meals are not intended to meet the full daily nutritional needs of a recipient. More than one provider may be used to meet a recipient's need.

5. Case managers determine the need for this service based on a standardized nutritional Profile, or assessment, and by personal interviews with the recipient related to his/her nutritional status.

6. All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services and the United States Department of Agriculture; and provide a minimum of 33 and 1/3 percent of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.
7. Nutrition programs are encouraged to provide eligible participants meals that meet particular dietary needs arising from health or religious requirements or the ethnic background of recipients.

2303.13B PROVIDER RESPONSIBILITIES

1. Meals will be provided by governmental or community providers who meet the requirements of a meal provider under NRS 446 and who hold a Physical Disability Waiver provider contract with the Division of Health Care Financing and Policy.

2. Pursuant to NRS 446: All nutrition sites which prepare meals must have a Food Service Establishment Permit as follows:

   a. All Nutrition Programs must follow the Health and Safety Guidelines established for Food and Drink Establishments in Nevada Administrative Code, Chapter 446, or local health code regulations.

b. All kitchen staff must hold a valid health certificate if required by local health ordinances.

c. Report all incidents of suspected food borne illness to the affected recipients within 24 hours and to the Medicaid District Office case manager within the next business day.

3. Prior to providing services, home delivered meal drivers are required to have a fingerprint search conducted by the Nevada Highway Patrol Criminal Information Services. The search will include a review of the records contained in the Nevada Criminal History Repository.

2303.14 EXTENDED DENTAL SERVICE

2303.14A COVERAGE AND LIMITATIONS

1. Dental service is available for recipients who require preventive services to stay healthy in a community environment.

2. This includes preventive dental services by a dentist and/or dental hygienist. Preventive dental services are limited to an oral examination bite-wing x-rays one time per year, and prophylaxis 1 to 2 times per year.

2303.14B PROVIDER RESPONSIBILITIES

Providers are those dentists who are Medicaid Providers and have met the criteria to be a Medicaid Provider per Chapter 1000 of the Nevada Medicaid Services Manual.

2303.15 ATTENDANT CARE

2303.15A COVERAGE AND LIMITATIONS

1. This service allows for personal care skilled service needs to be met by a personal attendant. This includes skilled or nursing care to the extent permitted by state law.

2. Where possible and preferred by the recipient, he/she will direct his/her own service either with an individual provider, an ISO, or a provider agency. Otherwise, a provider agency will supervise the assistants. The recipient will select his/her own assistant and may recruit the assistant and refer the assistant to the provider agency for hire. The recipient

may also terminate his/her assistant. When utilizing an independent contractor the recipient will work with his/her case manager to identify an appropriate back up plan. The agency will otherwise recruit, screen, and schedule assistants, provide backup and assurance of emergency assistance.

3. This service allows for the number of skilled hours as authorized by the Medicaid Case Manager or by the Quality Improvement Organization-like (QIO-like) to be completed by the attendant. It also allows an extension to the State Plan PCA unskilled hours authorized under the functional assessment (Form NMO 3244) for a specific functional area when there is professional documentation the service is necessary base on medically appropriate standard of care. The maximum allowable increase (above the state plan covered hours) for skilled and unskilled tasks, on an ongoing basis will not exceed the nursing facility standard rate, the nursing facility ventilator dependent rate, or the nursing facility pediatric specialty care rate, whichever rate is the rate the state would pay for the recipient in a nursing facility. Short-term increases based on time limited acute situation may exceed this rate. These increases are provided in 30 day increments, based on a review of the treatment plan and progress towards outcomes. This needs to be documented in the case notes by the case manager.

4. Extended personal care attendant services in the recipient's plan of care may include assistance with:

   a. eating;

   b. bathing;

   c. dressing;

   d. personal hygiene;

   e. activities of daily living;

   f. hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function.

5. To receive skilled care by an unskilled provider, the health care provider must follow all regulations under NRS 629.091, included in Section 2305.2 of this Chapter.

6. If the applicant/recipient is in a Medicaid or Medicare funded hospice program, the applicant/recipient is not eligible to receive this waiver service.

2303.15B PROVIDER RESPONSIBILITIES

1. This service can be provided by an individual provider or by a provider agency.

2. All persons performing services to recipients from this category will have criminal history clearances obtained from the Federal Bureau of Investigation through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services to recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. Reference in Section 2303.2B2.d of this Chapter.

3. Personal care assistance providers may be members of the individual's family. However, payment will not be made for services furnished by legally responsible adults. Spouses of recipients, and parents of minor recipients, including stepparents who are legally responsible for minor children, and legal guardians, are considered legally responsible adults. Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

4. If the provision of services is for unskilled services only, the qualifications for PCA services can be found in Medicaid Service Manual Chapter 3500.

5. If the provision of services includes an unskilled provider completing skilled care, qualifications and requirements must be followed as in NRS 629.091, see attached in Section 2305.2 of this Chapter.

6. Providers must demonstrate:

   a. the ability to perform the care tasks as prescribed;

   b. the ability to identify emergency situations and to act accordingly, including CPR certification which may be obtained outside the agency;

   c. ability to maintain confidentiality in regard to the details of case circumstances;

   d. the ability to document in writing the services provided.

7. Provider Agencies must arrange training in:

   a. procedures for arranging backup when not available, agency contact person(s), and other information as appropriate. (Note: This material may be provided separate from a training program as part of the provider's orientation to the agency.)

b. personal hygiene needs and techniques for assisting with activities of daily living, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.

c. home making and household care, including good nutrition, special lists, meal planning and preparation, shopping information, housekeeping techniques and maintenance of a clean, safe and healthy environment.

8. Individual Providers

a. The individual provider will need to understand the assigned tasks, the allotted time, record keeping responsibilities, and billing procedures for provided waiver services.

b. Individual providers must document the time spent and services provided to the recipient on a daily record. This record must be signed by the recipient and be available for the case manager's review.

c. Personal assistance service attendant care requires billing claim forms, CMS 1500, be initialed by a Medicaid case manager.

2303.16 PROVIDER ENROLLMENT/TERMINATION

All providers must comply with all DHCFP provider enrollment requirements, provider responsibilities/qualifications, and DHCFP provider agreement limitations. Provider non-compliance with all or any of these stipulations may result in Nevada Medicaid's decision to exercise its right to terminate the provider's contract.

2303.16A COVERAGE AND LIMITATIONS

1. All providers refer to the Medicaid Services Manual Chapter 100 for enrollment procedures.

2. The following is the required procedure for enrolling independent contractors as Personal Assistant Service Attendant Care (providers providing skilled nursing services by unskilled service personal care attendants) for Physically Disabled Waiver recipients.

2303.16B PROVIDER RESPONSIBILITY

1. The provider-applicant completes the Enrollment Form, the Information Request Form (3328), and the Medicaid Supplemental Questionnaire. Applicants for Attendant Care provider who will be providing skilled services as an unskilled provider must ensure the recipient they will care for has both a current physician authorization (Form 3428A) and a completed recipient authorization (Form 3426). Copies of these documents must be

submitted with their application. The Attendant Care provider applicant must also complete the Medicaid Provider Agreement for Provision of Skilled Service by an Unskilled Provider (Form 3427). They must have the training authorization (Form 3428B) completed by a health care provider indicating they have been trained in the provision of skilled service for their attendant care recipient. Form 3427 and Form 3428B must have original signatures. Form 3426 and 3428A may be copies if there is also a copy on the recipient's file at Medicaid.

2. Verification of the following is required and must be forwarded to Provider Support.

   a. FBI Background Test request (copies of cards and money orders)

   b. Worker's Compensation Insurance or signed NMO form waving insurance; and

   c. Social Security Card.

3. Medicaid Provider Support Unit will review the forms and verifications and if appropriate, send out the contract and addendum for the applicant to sign. A provider number cannot be issued until the contract and addendum are signed and returned.

4. The effective date on the contract will be the date all complete, accurate forms and verifications are received in Medicaid's District Office. Provider Support reviews the forms and verifications for accuracy once they are received in the central office. If discrepancies are found by Provider Support, the effective date on the contract will be the date all accurate paperwork is received in the District Office. Payment to providers is not guaranteed until the contract and addendum are returned and a provider number is issued. It is the provider's responsibility to make sure the signed contract and addendum is returned to Provider Support.

2303.16C RECIPIENT RESPONSIBILITY

Failure of the recipient to sign the Nevada Medicaid Physically Disabled Waiver Recipient Personal Assistance Service – Attendant Care Home Care Criteria (Form 3426), or the Medicaid Provider Agreement for Provision of Skilled Service (Form 3427) by an Unskilled Provider or to maintain a current physician authorization (Form 3428A) will result in the termination of receiving skilled services by an unskilled provider and denial of this service under the physically disabled waiver if there are no authorized unskilled extension hours. These forms assure the recipients understand the service limitations and the responsibilities to ensure their personal safety.

2303.17 INTAKE PROCEDURES

Nevada Medicaid has developed procedures to ensure fair and adequate access to Physically Disabled Waiver services.

2303.17A COVERAGE AND LIMITATIONS

1. SLOT PROVISION

a. The allocation of waiver slots is maintained at Medicaid's Central Office Waiver Unit with sublists located at the district offices. As waiver slots become available the Medicaid Central Office Waiver Unit determines how many slots each district office may have allotted and notifies each office.

b. If a physically disabled waiver recipient voluntarily terminates from the waiver, e.g., moves out of state, fails to cooperate, or requests waiver services be terminated, then at a later date, wants to be reconsidered for the waiver, that person's name will be placed on the waiting list based on the new referral date.

c. If a physically disabled waiver recipient involuntarily terminates from the waiver, e.g., has been placed in a nursing facility or hospital, and after discharge from the hospital or nursing home wants to be considered for the waiver, if the discharge occurred in the same waiver year, and if that person still meets the eligibility criteria, that recipient will be placed back on the physically disabled waiver.

2. TELEPHONE REFERRAL/PRELIMINARY SCREENING

a. A referral or inquiry for the waiver may be made by the potential applicant or by another party on behalf of the potential applicant by contacting a case manager for the waiver for people with physical disabilities at the applicants local Medicaid district office. The case manager will discuss the waiver including the eligibility requirements of the waiver with the referring party or applicant by telephone.

b. If the potential applicant wants to apply for the waiver, the case manager will assist the individual in completing and submitting the Welfare application, if needed.

c. During the referral process, if the case manager determines the applicant does not appear to meet the waiver criteria of financial eligibility, level of care, or disability determination, the applicant will be referred to other agencies for needed services.

d. Even if the applicant does not appear eligible for the physically disabled waiver, he/she must be verbally informed of the right to continue the application process and, if still deemed ineligible, the applicant has the right to a fair hearing.

3. WAITING LIST/NO WAIVER SLOT IS AVAILABLE

a. After the preliminary screening by Medicaid's district office staff has been completed, the staff determines if the applicant appears to meet the criteria to qualify for the waiver.

The applicant must also submit an application for Medicaid through the Welfare Division.

After an application has been received by Welfare eligibility for the applicant, and the applicant appears to meet the criteria to qualify for the waiver, the district office staff will schedule a face-to-face home visit with the applicant to determine level of care and service need screening.

1. The applicant must meet the criteria for nursing facility level of care.

2. The applicant must require at least one waiver service to be eligible for the waiver.

3. The applicant must be certified as physically disabled by Medicaid's Central Office Disability Determination Team.

4. If the applicant does not meet the program eligibility requirements and is denied, the case manager will send the Notice of Decision to the applicant.

5. If the applicant would be eligible given on available slot, the date of the initial referral will be considered the waiting list ranking date.

4. A WAIVER SLOT IS AVAILABLE

Once a slot for the waiver is available, an applicant who has been assigned a waiver slot will be reprocessed for the waiver.

a. Reprocessing for the waiver:

1. If the Welfare application is over 30 days old, the district office staff will assist the applicant with providing an updated application to Welfare within 10 days of Medicaid's waiver approval.

2. The district office staff will schedule a face-to-face home visit with the recipient to complete the full waiver assessment.

3. An Authorization for Release of Information Form is needed for all waiver recipients and provides written consent for the DHCFP to release information about the recipient to others.

   The applicant or designated representative must understand and agree that personal information may be shared with providers of services and others, as specified on the form.

   Per NRS 232.357, the Divisions within the Department of Human Resources may share confidential information without a signed Authorization for Release of Information.

4. The applicant/recipient will be given the right to choose waiver services in lieu of placement in a nursing facility. If the applicant or designated legal representative prefers placement in a nursing facility, the case manager will assist the applicant in arranging for facility placement.

5. The applicant/recipient will be given the right to request a hearing if not given a choice between home and community based services and nursing facility placement.

6. If the applicant/recipient is approved for the waiver and Medicaid waiver eligibility has been determined:

   a. A written Client Care Plan is developed in conjunction with the recipient by the district office case manager for each recipient under the waiver. The care plan is based on the assessment of the recipient's health and welfare needs.

   b. The recipient or the recipient's family or legal representative should participate in the development of the care plan.

   c. The Client Care Plan is subject to the approval of the Medicaid's Central Office Waiver Unit.

   d. Recipients will be given free choice of all qualified Medicaid providers of each Medicaid covered service included in his/her written care plan. Current care plan information as it relates to the services provided must be given to all service providers.

7. All forms must be complete with signature and dates where required.

8. If the applicant/recipient is denied waiver services, the District Office case manager will send the Notice of Decision (NOD) to the applicant.

5. EFFECTIVE DATE FOR WAIVER SERVICES

The effective date for waiver services approval is the completion date of all the intake forms and the Medicaid eligibility date, whichever is later. If the recipient resides in an institution, the effective date can not be prior to the date of discharge from the institution.

6. DISABLED WAIVER COST

Medicaid must assure CMS the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the institutional level of care under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2303.18 BILLING PROCEDURES

2303.18A COVERAGE AND LIMITATIONS

All Providers (58) for the waiver for people with physical disabilities must complete the CMS 1500 for payment of waiver services. Dental claims may be submitted on the American Dental Association form. Incomplete or inaccurate claims will be returned to the provider by Medicaid's fiscal agent. If the wrong form is submitted it will also be returned to the provider by Medicaid's fiscal agent.

2303.18B PROVIDER RESPONSIBILITY

Refer to First Health Services Corporation, Nevada Medicaid and Nevada Check Up, CMS-1500 Provider Billing Manual for detailed instructions for completing the CMS 1500 form.

2303.19 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed provider agencies providing personal care aide services to give their clients information about their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to Medicaid Services Manual Chapter 100 for further information.

2303.20 CASE MANAGER RECIPIENT CONTACTS

a. Monthly Contact

1. The case manager must have monthly contact with each waiver recipient, or a recipient representative; this may be a phone contact. At a minimum, there must be a home visit to each recipient every 6 months or more often if the recipient has

indicated a significant change in their health care status or there are reasons for concern about their health and safety.

2. During the monthly contact, the case manager determines if there are any issues with the service provision, the recipient's satisfaction with services, assesses for any changes in services or providers, and determines whether the services are promoting the goal(s) stated on the Client Care Plan.

b. Reassessment

1. The recipients level of care, functional status and needs addressed by the care plan must be reassessed at least annually. The first reassessment must be completed within 365 days of the waiver approval date. The recipient must also be reassessed when there is a significant change in his/her condition. The reassessment should be conducted in the recipient's home.

2303.21 MEDICAID'S ANNUAL REVIEW

The State will have in place a formal system in which an annual review will be conducted to assure the health and welfare of the recipients served on the waiver, the recipient satisfaction with the waiver, and assure the cost effectiveness of these services.

2303.21A COVERAGE AND LIMITATIONS

The state will conduct an annual review; and

1. provide CMS with information on the impact of the waiver. This includes the type, amount, and cost of services provided under the waiver and provided under the state plan and the health and welfare of the recipients served on the waiver.

2. assure financial accountability for funds expended for Home and Community Based services.

3. evaluate that all provider standards are continuously met and that plans of care are periodically reviewed to assure that services furnished are consistent with the identified needs of the recipients.

4. evaluate the recipient's satisfaction with the waiver program.

5. further assure all problems identified by this monitoring will be addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

2303.21B PROVIDER RESPONSIBILITIES

Providers must cooperate with Medicaid's annual review process.

2304 HEARINGS

2304.1A SUSPENDED WAIVER SERVICES

1. If it is likely the recipient will be eligible again for waiver services within the next 60 days (for example: if a recipient is admitted to a hospital or nursing facility a recipient's case may be suspended, instead of closed,). A NOD (Notice of Decision) identifying the effective date and the reason for suspension will be sent to the recipient by the district office.

2. If at the end of the 45 days the recipient has not been removed from suspended status, the case must be closed. A Notice of Decision (NOD) identifying the 60th day of suspension as the effective date and the reason for termination will be sent to the recipient by the district office.

2304.1B RELEASE FROM SUSPENDED WAIVER SERVICES

If a recipient has been released from the hospital, nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) before 60 days the case manager, within 5 working days of release must:

1. complete a new Level of Care Assessment Tool, if there has been a significant change in the recipient's condition or if it appears they may not meet a level of care;

2. complete a revised Social Health Assessment, if there has been a significant change in the recipient's condition;

3. complete a new Client Care Plan if there has been a change in services (medical, social, or waiver). If a change in services is expected to resolve in less than 30 days a new Client Care Plan is not necessary. Documentation of the temporary change must be made in the case manager's notes. The date of resolution must also be documented in the case manager's notes;

4. complete a new Cost Projection form if there is a change in the Client Care Plan;

5. contact the service provider(s) to reestablish services.

2304.1C DENIAL OF WAIVER APPLICATION

Reasons to deny an applicant for waiver services:

1. The applicant does not meet the criteria for being physically disabled.
2. The applicant does not meet the level of care criteria for nursing facility placement.

3. The applicant has withdrawn their request for waiver services.

4. The applicant fails to cooperate with the Medicaid Case Manager or home and community based services providers in establishing and/or implementing the plan of care, implementing waiver services, or verifying eligibility for waiver services. (The recipient's or the recipient's authorized representative's signature is necessary for all required paperwork).

5. The applicant's support system is not adequate to provide a safe environment during the time when home and community based services are not being provided.

6. Medicaid has lost contact with the applicant.

7. The applicant fails to show a need for home and community based waiver services.

8. The applicant would not require nursing facility placement if home and community based services were not available.

9. The applicant has moved out of state.

10. Another agency or program will provide the services.

11. The Nevada Medicaid office has filled the number of positions allocated to the Home and Community Based Waiver Program for people with physical disabilities. The applicant will be approved for the waiver waiting list and will be contacted when a slot is available.

When the application for waiver services is denied the case manager will send a Notice of Decision (NOD) for Prior Authorization Request (Form 3582) to the applicant or the applicant's legal representative. The case manager will submit the form within 5 days of the date of denial of waiver services. Refer to Medicaid Services Manual Chapter 3100 for detailed policy on appeals and hearings.

2304.1D TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver or to terminate the recipient from the waiver waiting list:

1. The recipient has failed to pay his/her patient liability.

2. The recipient no longer meets the criteria for being physically disabled.
3. The recipient no longer meets the level of care criteria for nursing facility placement.

4. The recipient has requested termination of waiver services.

5. The recipient has failed to cooperate with the Medicaid case manager or home and community based services providers in establishing and/or implementing the plan of care, implementing waiver services, or verifying eligibility for waiver services. (The recipient's or the recipient's authorized representative's signature is necessary on all required paperwork).

6. The recipient's support system is not adequate to provide a safe environment during the time when home and community based services are not being provided.

7. The recipient fails to show a continued need for home and community based waiver services.

8. The recipient no longer requires nursing facility placement if home and community based services were not available.

9. The recipient has moved out of state.

10. The recipient has submitted fraudulent documentation on Attendant Care provider time sheets and/or forms.

11. Another agency or program will provide the services.

12. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, intermediate facility for persons with mental retardation, or incarcerated).

13. Medicaid has lost contact with the recipient.

When a recipient is terminated from the waiver program, the case manager will send to the recipient or the recipient's legal representative a Notice of Decision Form 3582. The form must be mailed by the agency to the recipient at least 13 calendar days before the Date of Action on the form. Refer to Medicaid Services Manual Chapter 3100 for exceptions to the advance notice.

2304.1E REDUCTION OF WAIVER SERVICES

Reasons to reduce of waiver services:

1. The recipient no longer needs the number of service hours which were previously provided.
2. The recipient no longer needs the service previously provided.

3. The recipient's support system is providing the service.

4. The recipient has failed to cooperate with the Medicaid case manager or home and community based services providers in establishing and/or implementing the plan of care, implementing waiver services, or verifying eligibility for waiver services. (The recipient's or the recipient's authorized representative's signature is necessary on all required paperwork).

5. The recipient has requested the reduction of services.

6. The recipient's ability to perform activities of daily living has improved.

7. Another agency or program will provide the service.

8. Another service will be substituted for the existing service.

9. The recipient fails to cooperate with the necessary procedures and signatures for enrolling any physically disabled waiver service provider.

When there is a reduction of waiver services the case manager will send a NOD Form 3582 to the recipient or the recipient's legal representative. The form must be mailed by the agency to the recipient at least 13 calendar days before the Date of Action on the form.

2304.2 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

2304.2A COVERAGE AND LIMITATIONS

1. If waiver services have been terminated and the recipient/applicant is eligible for readmission to the waiver as defined in Section 2303.17 A.1.b. and c. and is requesting reapproval within 90 days of closure the case manager must complete the following:

   a. a new Level of Care and Service Placement Assessment Tool;

   b. a Social/Health Assessment/Adjunct;

   c. the Statement of Understanding;

   d. the Client Care Plan; and

   e. the Disability Waiver Cost Projections.

   All forms must be complete with signatures and dates.

2. If a recipient is terminated from the waiver for more than 90 days, and slots are available, and the recipient/applicant is eligible for readmission to the waiver as defined in Section

2303.17A.4. a new complete waiver packet for a new authorization must be forwarded to the Medicaid Central Office Waiver Unit.

2304.2B Please refer to Chapter 3100 for the Medicaid Hearing process.

2305 REFERENCES AND CROSS-REFERENCES

MEDICAID SERVICE MANUAL (MSM)

MSM Chapter 100, Provider Qualifications, Enrollment Procedures, Living wills and Durable Power of Attorney
MSM Chapter 500, Level of Care
MSM Chapter 1000, Dental Provider Qualifications
MSM Chapter 1300, DME Provider Qualifications
MSM Chapter 1400, Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
MSM Chapter 1900, Medical Transportation
MSM Chapter 3100, Hearings
MSM Chapter 3500, Functional Assessment, PCA, Service Plan
MSM Chapter 3600, Managed Care Organization
MSM Chapter 3700, Nevada Check Up
Medicaid Eligibility MAABD Manual Section 360

2305.1 Contacts

a. Medicaid District Offices

1. Las Vegas (Covers Pahrump and Henderson.)
700 Belrose Street
Las Vegas, NV 89107
(702) 486-1550

2. Reno
1030 Bible Way
Reno, NV 89502
(775) 688-2811

3. Carson City
755 N. Roop St, Suite 201
Carson City, NV 89701
(775) 684-0826

4. Elko (Covers Ely and Winnemucca.)
850 Elm Street
Elko, Nv 89801
(775) 753-1191

5. Fallon (Covers Tonopah, Yerington and Hawthorne.)

111 Industrial Way
Fallon, NV 89406
(775) 423-3161

b. Other Contact information

PROVIDER RELATIONS UNITS

Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

PRIOR AUTHORIZATION DEPARTMENTS

First Health Services Corporation
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395

PHARMACY POINT-OF-SALE DEPARTMENT

First Health Services Corporation
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238

2305.2 Nevada Revised Statutes: Chapter 629 NRS 629.091

NRS 629.091 Personal assistant authorized to perform certain services for person with physical disability if approved by provider of health care; requirements.

1. Except as otherwise provided in subsection 4, a provider of health care may authorize a person to act as a personal assistant to perform specific medical, nursing or home health care services for a person with physical disability without obtaining any license required for a provider of health care or his assistant to perform the service if:

a. The services to be performed are services that a person without a physical disability usually and customarily would personally perform without the assistance of a provider of health;

b. The provider of health care determines that the personal assistant has the knowledge, skill and ability to perform the services competently;

c. The provider of health care determines that the procedures involved in providing the services are simple and the performance of such procedures by the personal assistant does not pose a substantial risk to the person with a physical disability;

d. The provider of health care determines that the condition of the person with a physical disability is stable and predictable; and

e. The personal assistant agrees with the provider of health care to refer the person with a physical disability to the provider of health if:

1. The condition of the person with a physical disability changes or a new medical condition develops;

2. The progress or condition of the person with a physical disability after the provision of the service is different than expected;

3. An emergency situation develops; or

4. Any other situation described by the provider of health care develops

2. A provider of health care that authorizes a personal assistant to perform certain services shall note in the medical records of the person with a physical disability who receives such services:

a. The specific services that he has authorized the personal assistant to perform; and

b. That the requirements of this section have been satisfied.

3. After a provider of health care has authorized a personal assistant to perform specific services for a person with a physical disability, no further authorization or supervision by the provider is required for the continued provision of those services.

4. A personal assistant shall not:

a. Perform services pursuant to this section for a person with a physical disability who resides in a medical facility.

b. Perform any medical, nursing or home health care service for a person with a physical disability which is not specifically authorized by a provider of health care pursuant to subsection 1.

5. A provider of health care who determines in good faith that a personal assistant has complied with and meets the requirements of this section is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.

6. As used in this section:

a. "Personal assistant" means a person who, under the direction of a person with a physical disability and for compensation, performs services for the person with a physical disability to help him maintain his independence, personal hygiene and safety.

b. "Provider of health care" means a physician licensed pursuant to chapter 630.630A or 633 of NRS, a dentist, a registered nurse, a licensed practical nurse, a physical therapist or an occupational therapist.